

MDR Tracking Number: M5-05-0433-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-1-04.

The IRO reviewed electrical stimulation, office visit, DME, massage, mechanical traction, ultrasound, chiropractic manipulative treatment, self-care/home training on 11-14-03 to 12-31-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO agrees with the previous adverse determination that the electrical stimulation, office visit, self-care/home training, and DME were not medically necessary. The IRO deemed the massage, mechanical traction, ultrasound, and chiropractic manipulative treatment were medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services not addressed by the IRO and will be reviewed by the Medical Review Division. On 1-18-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Codes 97012, 97032, and 97035 billed for dates of service 10-27-03 to 11-12-03 and 11-20-03 were denied as "N, 205 – this charge was disallowed as additional information/definition is required to clarify service/supply rendered." The daily notes on 10-27-03 and 11-12-03 state that 'therapy will include' and 'therapy will continue as planned'. These statements do not support that services were actually performed. Requestor did not submit daily note for 11-20-03. Therefore, no reimbursement recommended.

Code 97124-59 billed for dates of service 10-27-03 to 11-12-03 and 11-20-03 was denied as 'F, 435 – the value of this procedure is included in the value of the comprehensive procedure.' The carrier did not identify the comprehensive procedure. However, no reimbursement can be recommended since the daily notes state that 'therapy will include' or 'therapy will remain unchanged from previous visit'. These statements do not support that services were actually performed.

Requestor submitted a withdrawal letter for Code 99080-73 billed for date of service 12-17-03 since payment was received.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- In accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service on or after August 1, 2003 per Commission Rule 134.202 (e)(8);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 11-14-03 through 12-31-03 as outlined above.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 26th day of January 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



Specialty Independent Review Organization, Inc.

Amended Decision 1-21-2005

December 3, 2004

Hilda Baker
TWCC Medical Dispute Resolution

7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-0433-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

Based on the records received and reviewed, the injured employee, ___, was injured in a work related accident on ___. ___ was working for Wal-Mart as an unloader performing manual labor when he was injured by lifting heavy objects, including disassembled bookcases, when he felt on onset of pain. The patient reported on low back pain and pain in the mid back region. He initially presented to Oasis Clinic where he was prescribed medications. He then transferred his care to Dr. Fields who initiated a course of conservative treatment with ___. ___ was referred out for MRI's to the thoracic and lumbar areas. ___ also received electrodiagnostics to the lower extremities due to radiating pain in the legs. ___ continued his care with Dr. Fields and according to the records reviewed did not require any invasive procedures during the time under review.

The records include but are not limited to the following:

Records received from the carrier
Records received from the treating doctor
Medical Dispute Resolution paperwork
Multiple EOB's
Multiple TWCC-73's
Retrospective review by Dr. Hamby

Retrospective review by Dr. Hayes
Letter dated 11-5-2004 by Dr. Fields
Open Air MRI of the Lumbar region
Open Air MRI of the Thoracic region
Kothmann Chiropractic and Rehabilitation electrodiagnostic report
FCE date 10-31-2003
Records from Dr. Fields
Arkansas Claims Management Summary
Records from Dr. Dzik
Records from Mari Johnson RN
Report from PI Solutions
Report from Dr. Golovko
FCE by Healthsouth

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of physical medicine services, CPT codes 97124-59, 97012, 97032, 97035, 98942, 99214, 97535 and DME code E1300 from 11-14-2003 through 12-31-2003.

DECISION

The reviewer agrees with the previous adverse decision regarding 97032, 97535, 99214 and E1300. The reviewer disagrees with the previous adverse decision regarding all other services under review for the dates under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, Evidenced Based Medical Guidelines, and Medicare Payment Policies. The documentation does not support the level of examination in regards to 99214 according to CMS and Medicare Payment Policies to code a level 4 examination. The documentation also does not support 97032 in that 97032 is an attended therapy and the documentation does not support the necessity of a constant attended modality over a supervised modality. In addition the documentation received and reviewed does not identify the application of a DME on 11-17-2003 and there is also no record of the necessity or use of DME on 11-17-2003. The documentation also does not support the three units of 97535 on 11-24-2003. Considering the fact that ___ works as a laborer performing heavy lifting, the treatment under review falls within clinically accepted guidelines as identified above. The patient also has complicating factors of spinal canal stenosis and degenerative disc disease. Although these conditions may not have been directly caused by the work related injury, they are nonetheless complicating conditions that would alter the patient's recovery time and prognosis and thus the treatment falls within acceptable time periods.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director